US Decisions Inc.

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DATE NOTICE SENT TO ALL PARTIES: Oct/28/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: inject spine lumbar/sacral

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for an inject spine lumbar/sacral is not indicated as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back. The therapy note dated xxxxx indicates the patient having completed 22 physical therapy sessions to date. The MRI of the lumbar spine dated xxxxx revealed a posterior disc herniation at L4-5 measuring approximately 4.5mm with minimal right sided lateralization. Moderate central spinal canal and right lateral recess stenosis was identified. A 2mm disc bulge was also identified at L5-S1 without stenosis. The clinical note dated xxxx indicates the patient complaining of 7-8/10 pain in the low back. Radiating pain was identified into the right lower extremity. The patient also reported numbness and tingling in the right lower extremity. Weakness was also identified in the right lower extremity. The clinical note dated xxxx indicates the patient continuing with 7-9/10 pain. The patient described an aching pain with numbness and tingling. The patient was recommended for an L4-5 epidural injection at that time. The clinical note dated xxxxx indicates the patient complaining of a throbbing and tingling sensation. The patient reported the pain comes and goes. Radiating pain continued into the right lower extremity. The clinical note dated xxx indicates the patient complaining of constant pain at that time. The patient was recommended for an L4-5 epidural injection.

The utilization reviews dated xxxxx and xxxxxx resulted in denials as no significant findings consistent with radiculopathy were identified specifically in the L4-5 level.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of a long history of ongoing low back pain despite the completion of a full course of physical therapy. There is an indication the patient has sensory deficits identified in the L3 level. However, no information was submitted regarding any radiculopathy findings consistent at the L4-5 level. Furthermore, the patient's reflexes were identified as normal. There is an indication in the earlier clinical notes regarding weakness in the right lower extremity. However, the more recent clinical notes indicate the patient showing no strength deficits. Given the lack of clinical findings confirming a radiculopathy in the appropriate distribution, the request is not indicated. As such, it is the opinion of this reviewer that the

request for an inject spine lumbar/sacral is not indicated as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)